# PATIENT
# REVOKE OPT-OUT

**As of December 19, 2013**

| Patient Name | Date of Birth | Date Form Signed |
|---|---|---|
| Patient Address: Street, City, State, Zip Code | | |
| Telephone Number | Cell Phone Number | Email |

☐ REVOKE OPT-OUT. I previously elected to opt-out of One Health Record but have changed my mind. As of today's date, I elect to REVOKE (cancel) my decision to OPT-OUT of One Health Record. I wish to participate in One Health Record, and I understand my health information and/or records will now be shared through One Health Record.

| | | |
|---|---|---|
| **Signature of Patient** or Authorized Representative | Printed Name of Health Care Provider/Facility where signed and NPI#_____ | Date |

Authorized Representative
Print name of Authorized Representative:_____

Authority to sign on behalf of patient (e.g., health care power of attorney, guardian, parent of minor):_____

If the Patient or Authorized Representative does not sign this *Revoke Opt-Out form* at a health care provider's facility or office, then the signature of the Patient or Authorized Representative must be notarized below.

| | | |
|---|---|---|
| Notary Public | Date of Expiration of Commission | Date Notarized |

Please complete this form, sign, and submit originals to:

_____